Premium Variation in the Small-Group Market in Delaware: Analysis of the Problem and Possible Solutions

prepared for

Small Business Committee
Delaware Health Care Commission

by

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September 2005

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Small employers seeking to purchase health insurance in Delaware face two distinct but related problems. The first is that the average cost of coverage is high and continues to rise at rapid rates. The second is that some small employers pay premiums that are far higher than others. Both of these problems impose financial burdens on small employers and in some cases may make coverage unaffordable.

The first problem—the high costs that all small employers face—is not unique to the small-group market. It is a reflection of the rapid escalation of the cost of delivering medical care everywhere. In Delaware and across the country, medical care cost increases outpace the growth of the economy as a whole. For example, between 2000 and 2003, national health expenditures grew by 28.2 percent, while Gross Domestic Product rose by only 12.1 percent.[1] This disparity is reflected in business costs, as well. During the same period, U.S. private business spending for wages and salaries grew by 3.7 percent, while business health spending grew by 23.5 percent.[2]

Because payment of medical claims makes up the bulk of the cost of health insurance, when medical costs rise, premiums rise at similar rates. The impact on small employers is especially severe, for two reasons. First, many small firms have difficulty absorbing large premium increases because they operate with small profit margins. They don't have the reserves that would help them weather a large increase in expenses, especially when the change is unpredictable. Second, the average cost of coverage is higher for small employers than for large employers because insurers incur higher administrative costs in serving them. It is inherently more expensive to market to and provide needed services for 100 firms of 10 employees each than it is to do

[1] Center for Medicare and Medicaid Services website, Table 1: National Health Expenditures Aggregate and per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1980-2003, http://www.cms.hhs.gov/statistics/nhe/historical/t1.asp

[2] Cathy A. Cowan and Micah B. Hartman, "Financing Health Care: Businesses, Households, and Governments, 1987-2003, Health Care Financing Review/Web Exclusive, July 2005, Vol. 1, No. 2

the same for one firm of 1,000 employees. It is hard to document how much of a cost differential these diseconomies of scale produce, but everyone agrees that there is a significant effect. One recent study of administrative cost differences estimated that premiums for small groups are up to 20 percent to 30 percent higher than for large groups for the same claims per covered employee.[3]

In some ways, the general problem of high health care costs and premiums is the more important of the two problems identified earlier. Unless something is done to curb overall cost increases, reducing the disparity of rates paid by small employers will ultimately not be very effective. Even if rate differences were eliminated entirely, premium increases that continuously outpace other business costs would still make coverage unaffordable for some small employers. And anything that would reduce the rate of general cost escalation would make the problems created by rate disparities less severe.

But health cost escalation is a problem that is beyond the scope of this project. The country has been struggling to find workable solutions to the cost problem for many years, without long-range success. To a large degree, cost escalation in Delaware will inevitably follow national trends. Some of our informants argued that special conditions in Delaware contribute to a high cost base—for example, the fact that there is only limited competition among providers, especially hospitals, because of the small number. But even if the cost *base* could be reduced in the state, the long-run rate of increase is likely to parallel national trends. States can do some things to limit costs, and efforts in that direction are worth taking. But they probably cannot do much to control underlying changes in medical technology and Americans' insatiable taste for the fruits of these technologies, elements that are key drivers of cost escalation.

Perceptions of the Problem

This report will focus, then, not on the overall cost of health insurance but rather on the disparities in premiums facing small employers. To augment our understanding of the dimensions of the problem in Delaware, we began our work by interviewing a number of people in the state with knowledge about and interest in the small-group market. Our informants included insurance agents and brokers, health plans executives, small business people, business associations, and high-level state insurance regulators.

The general view of those we interviewed was that the small-group insurance market is not doing an ideal job of serving the needs of all small employers. Almost everyone agreed that the generally high level of insurance premiums and large year-to-year increases are a problem. Even for those employers who offer coverage, the increases impose a financial strain on their businesses. The high cost makes coverage completely unaffordable for many small employers. One insurance company executive

[3] Actuarial Research Corporation, *Study of the Administrative Costs and Actuarial Values of Small Health Plans,* prepared for SBA Office of Advocacy, under contract number SBAHQ-01 01-M-0811, January 2003. The estimates are based on a study of insurers in West Virginia and Colorado.

did suggest, however, that affordable products are available for almost all small employers, though perhaps not products that are as comprehensive as they have come to expect. But, as already noted, we will not focus on the overall cost and affordability of health insurance premiums but, rather, on the premium variations.

With the exception of the insurance company executives, most other respondents think that the small-group market is not performing particularly well. They generally agreed that the wide variation in rates paid by small groups is a deficiency. Insurers charge different premiums to different groups depending on the insurer's assessment of the risk that the people covered under each employer's plan will incur significant medical expenses. State law and current insurer practices allow theoretical premium variations of more than 9 to 1. Actual variations in premium rates of 4 or 5 to 1 occur with some frequency; that is, an employer with a substantially older, less healthy work force may pay five times the premium that would be offered to an employer with the youngest, healthiest work force. And a single employer can experience a very large increase from one year to the next, as might happen if one or two employees pass an age demarcation that puts the firm into the next higher risk category or because someone in the group develops a chronic disease or other serious illness. The largest premium renewal increases—sometimes 40 percent to 60 percent—occur when changes in the characteristics of people in an individual firm's workforce cause rate hikes that are added on top of the general increase in premiums ("trend") that is passed on to all insured small firms.

The size of such increases is obviously a problem, but so is the year-to-year instability and unpredictability for individual firms. Small employers often have very limited discretionary resources and little financial flexibility. So they have difficulty absorbing large, unexpected cost increases. They would find it easier to cope with the increases if the year-to-year changes were more similar in size and predictable, because it would then be possible to budget for them, even if the aggregate increase over a period of years was the same.

Although premium increases of the sort described impose a financial burden on small firms, insurance agents and industry executives indicated that they did not yet see signs of large numbers of small employers dropping coverage. Instead, employers were more likely to look for other ways to cut costs. They pass on more costs to employees by increasing deductibles and other forms of cost-sharing, by changing the benefits structure in other ways, or by switching carriers. Some analysts argue that this cost shift helps explain why more workers are declining employer-sponsored coverage, which is a major cause of the increase in the number of uninsured, particularly among low-wage workers. Even if employers are not dropping coverage in large numbers, they do express frustration and a sense of unfairness when faced with such large increases. The insurance regulators report that a high proportion of the complaints they receive are about large premium increases, a sign that people view the system as unfair and unpredictable.

Finding affordable coverage is frequently a problem for small businesses, but unlike people applying in the individual market, small employers cannot be denied cover-

age, regardless of their risk profile. State and federal law require that insurers offer small groups coverage on a guaranteed-issue basis.

Preliminary Observations

It is important to note that this problem is not due simply to the failure of insurers to adopt more enlightened practices, such as going back to community rating and charging the same or a similar rate to all groups regardless of their risk characteristics. If one insurer were to decide to "compress" premium variation—charging lower premiums to higher-risk groups and somewhat higher-premiums to lower-risk groups—they would almost certainly experience adverse selection. Because they would be offering lower rates than their competitors to high-risk groups, they would attract a disproportionate number of such groups. At the same time, they would begin to lose lower-risk groups, who could get a better price from competitors who maintained the wide rate variation. Losing low-risk groups while gaining high-risk groups is a formula for financial failure, because high-risk groups incur high medical costs while low-risk groups incur low medical costs (on average).

The lesson is that, to remain competitive, an individual insurer cannot stray far from implementing the extremes of rate variation that are permitted under the law. Movement toward greater uniformity of rates can be accomplished only by changing the state laws that govern allowable rate variation or through state actions that reduce the financial reward for segmenting risk. As long as insured individuals or groups are free to leave one insurer and move to another, no insurer can "pool" risks using substantially more lenient rules than those used by other insurers. For the same reasons, a purchasing pool that is open to all small employers cannot pool risks using different rating rules than the rest of the market outside the pool. The situation is different in the large-group market. Large employers can and do employ community rating, charging the same amount regardless of employees' age or medical risk. They can employ this approach because they have a "captive" group: low-risk employees would not gain a financial advantage by going out to buy insurance on their own because they would lose the employer's premium contribution and thus have to pay the entire premium themselves, and a higher premium at that. In addition, employees buying their own coverage would lose a major tax benefit: employer-paid health insurance premiums are not taxable as income, but premiums paid for individually purchased insurance are paid with *after*-tax income.

It is also important to recognize that when insurance regulations permit premium rating based on risk-related characteristics, insurers have an incentive to be very effective in detecting risk differences among the groups that seek coverage—the process called medical underwriting and risk segmentation. Insurers that are more effective than their competitors in separating higher-risk and lower-risk groups can offer the lower-risk groups a lower premium (because their claims will be lower) and thereby gain market share. The rewards to be gained from effective risk segmentation create incentives for insurers to invest resources in developing effective medical underwriting mechanisms. Since, roughly speaking, just 10 percent of any population group accounts for about 70 percent of the medical claims costs in any period, the

rewards for not enrolling the 10 percent who are heavy utilizers of medical services are very strong. Experience in other states suggests that some smaller insurers have tried to create a niche for themselves by being very aggressive in doing medical underwriting. However, from the standpoint of the public interest, this investment in medical underwriting, whoever does it, is a waste of resources. It does nothing to improve the real value of health care. It does not lower overall health costs, improve quality, or enhance levels of service.

The Range of Possible Solutions

If the state decides that steps need to be taken to reduce the disparities in premiums that face small employers with different risk characteristics, it can choose from a variety of approaches. All of them involve spreading risk over a broader population. One approach is to spread risk more broadly over just the small-group market, and within this approach there are two subcategories: the first is to *prohibit* wide rate variations by limiting what insurers are allowed to do; the second is to reduce the *incentives* for insurers to engage in risk segmentation and rate variation. A second approach is to spread risk more broadly *over the whole population* by using state general revenues to subsidize premiums for high-risk groups or individuals. We now turn to a discussion of specific policies that fall into these categories.

Reducing Allowable Rate Variation

As noted above, Delaware's small-group rating laws (Chapter 72 of the Insurance Code) gives insurers great latitude, allowing a wide range of variation. Among the states that have adopted rating restrictions, Delaware's rules are among the more permissive, although similar to many. The Delaware law is based on model legislation drafted by the National Association of Insurance Commissioners (NAIC), although Delaware's law allows insurers somewhat greater latitude to vary premiums rates.

The provisions of the Delaware law are complicated and difficult to understand and interpret. Some of the allowable rating factors can be used to vary rates from group to group, others from year to year. The factors include gender, geography, age, claims experience, health status, duration of coverage, industry, group size, unhealthy lifestyle choices, and up to nine different classes of business. These factors have different individual limits and apply in different circumstances, and they interact in complex ways. Current regulators suggest that the complexity makes interpretation and effective enforcement difficult if not impossible, and a number of observers indicated that the previous insurance regulators tended to devote few resources to enforcement except in a pro forma way, probably for the same reasons. This is not to suggest that insurers have been routinely or even occasionally violating the law in any intentional way, but it does indicate that whatever constraints the law places on insurer's rating practices are largely self-imposed. The conclusion is that the rating laws allow wide premium variation and that this creates problems of affordability for high-risk groups.

The people we interviewed frequently expressed the opinion that at the time when Delaware's small-group insurance reform law was initially passed in 1992, the expectation was that it would be more effective in limiting rate variation than has proved to be the case. For example, a paper prepared by the Health Care Commission urging small business support for the pending legislation observed that the proposed bill "would prohibit insurance companies from dramatically varying small employer health insurance premium rates from the rates of other groups based on certain demographic factors."[4] The paper goes on to say, "The reforms instituted by [the proposed legislation] will allow more small business people to provide health insurance for their employees in a stable and more predictable environment . . . ." That kind of language, while technically accurate, may have helped to create the impression that the law would bring greater changes than it has.

The law's apparent failure to achieve some of the hoped-for results appears to have caused some people in the state to question the relevance of the law in current circumstances. It is true that some of the original provisions of the state's small-group insurance laws have been changed—in most cases strengthened—to comply with federal requirements mandated by passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA required states to enact legislation that would require insurers to offer all small-group plans on a guaranteed-issue basis (no group can be denied coverage), to limit pre-existing condition restrictions and waiting periods, and to put in place other provisions to enhance portability of coverage. The federal law, however, did *not* impose any requirements regarding insurers' ability to vary premium rates from group to group, leaving this aspect of small-group regulation entirely up to states. So the provisions of Chapter 72 that limit rate variation are very relevant still, in the sense that without them, insurers would be completely free to vary rates as much as they wished, and over time rate variation would almost certainly exceed what is experienced now. The law has also curtailed the worst of insurer "cherry picking," which the Delaware Health Care Commission in 1992 described as the practice of "offering low-cost coverage for groups with young, healthy employees with little risk of needing substantial heath care. Once a member of this group needed to access health care, the insurance company's response would be to either drop coverage or dramatically hike premiums, forcing the employer into difficult decisions."[5]

The correct question to ask in assessing the relevance of the rating provisions of Chapter 72 is whether the state's rating rules need to be made *more* restrictive to reduce the current extent of premium variation.

It is certainly possible to reduce both allowable rate variation and complexity at the same time. Maryland provides a clear example. In that state, insurers selling coverage in the small-group market can use only two factors (other than family size) in rating a policy—age of the firm's employees and geographic location—and the total variation cannot exceed ± 40 percent for the two factors in combination, which is a ratio of

[4] Delaware Health Care Commission, "Insurance Reform Agenda," Sept. 21, 1992.
[5] Ibid.

about 2.3:1. (To take a simple example, if the premium for a small group of average risk is $10,000 per month for a particular type of coverage, then the premium for the highest-risk group cannot be more than $14,000, and the lowest-risk group must be charged at least $6,000. The figure of $14,000 is a little more than 2.3 times the figure of $6,000.) This is not community rating, but it moves in that direction. New York goes to the extreme: it uses pure community rating, with no adjustments even for age. All other states that have rating laws allow variation for at least age and usually some other factors as well.

Community rating was once the standard practice for insurers like Blue Cross and Blue Shield, but it was abandoned in self-defense as other insurers began to use experience rating and risk rating. The argument for community rating is that no one has to pay a higher rate because of conditions largely beyond their control, such as age, where they work or live, or previous medical history. Community rating is the extreme of applying the insurance principle of spreading risk: the healthy subsidize the not-so-healthy, with everyone in the same rating pool and everyone paying the same rates for identical coverage. Premiums for higher-risk people are lower under community rating than under any other rating approach, which means they are more likely to buy coverage. The corollary is that rates are highest for low-risk people under this approach, which makes them *less* likely to buy coverage. It could be argued that if a choice must be made between covering high-risk people and low-risk people, it is the high-risk individuals that are most likely to need the financial protection of good insurance.

The arguments against community rating are both theoretical and practical.

The theoretical argument is that community rating is inefficient: by increasing the price for low-risk people, community rating discourages them from buying as much coverage as they really would prefer—and would buy—if their price were not artificially raised. Under community rating, low-risk people have to pay more than the resource cost of providing them with coverage, which is, in terms of economic theory, an inefficient result.

The practical argument is that community rating will discourage too many low-risk people from buying coverage. Some people who anticipate seldom needing services—that is, who are low risk—will be unwilling to buy coverage when it is priced at the cost of covering the average enrollee and thus reflects the costs of all those who will incur expensive claims. If the low-risk people drop out, not only will they not have coverage; the price of coverage for everyone else will rise.

Some people also argue that community rating without any adjustment for age is not equitable, since older (and thus higher-risk) people typically have higher incomes and thus greater ability to pay than younger, lower-risk people, who are often just starting careers and earn lower incomes.

Another possible problem with going too far in the direction of community rating, especially in a small state like Delaware, is that some insurers may leave the state. As

noted earlier, some small insurers remain profitable by being very skillful at medical underwriting and risk rating: they manage to be more successful than competitors at attracting low-risk groups and avoiding high-risk groups. Community rating eliminates their ability to do that. If risk selection is a significant source of their profits, they may not find it worth staying in a small state like Delaware, where the volume of business is small relative to other large states. Whether the loss of insurers whose competitive advantage is being good at selecting risk is a real loss or not is a question for policymakers to decide.

Of course, virtually no one would endorse the opposite of pure community rating, which is complete self-insurance, since for individuals that means no spreading of risk, no insurance at all. The issue is where to come down between the two extremes. Many states have opted for "adjusted" community rating, which generally rules out the use of any health status factors or previous medical history in setting rates but almost always allows variation for age and often for gender, industry type, and firm location.

It is useful to consider criteria that could be applied in deciding what factors are appropriate to permit insurers to use in rating small groups. Some appropriate criteria are listed below:

1. The insurance principle is based on spreading risk, so it seems reasonable to start with the proposition that any departure from community rating needs to be justified, the justification being that it conflicts with other criteria reflecting other values.

2. Rating practices should avoid penalizing people for factors over which they have little or no control. People cannot control their gender or age. They have some control over their medical condition or health status, to the extent that these risk factors are affected by behavioral and lifestyle choices. But even these factors are strongly influenced by genetic and environmental factors that individuals cannot control. To base rate differences on characteristics beyond individuals' control conflicts with common notions of equity and fairness.

3. Rating regulations need to avoid rate variation that makes coverage unaffordable for high-risk groups (that is, for people who could afford coverage if they could get it at a community rate).

4. Rating regulations need to prevent low-risk groups from dropping coverage because it is so costly that they decide it is not worth the price. This criterion is obviously in conflict with the previous one.

5. Where practical, rating regulations should create incentives that encourage behavior that reduces medical costs, such as avoiding smoking or other lifestyle choices that produce poor health and high costs. This criterion seems straightforward, but it raises difficult questions

about how far government should go in trying to influence behavior and about who should decide which behaviors are good or bad.

6. Rating regulations, to the extent practical, should result in rating practices that are consistent with equity, specifically ability to pay. For example, some have argued that community rating unfairly requires young people, who often have low incomes, to pay the same premiums as older, higher-income people.

7. Rate regulations should avoid putting insurers in the position of not being able to compete effectively just because of past history—for example, because their enrollees are older and sicker than those of other insurers. If each insurer is forced to community rate all its groups together rather than being able to establish different "classes" of business with different rates for each class, an insurer that for historical reasons had an older population of enrollees would be at a disadvantage relative to another insurer, perhaps a new entrant to the market, that had a younger population. The insurer with the older population would have higher claims costs and thus could not offer rates that are low enough to attract younger, healthier workers. They would lose them to other insurers. Their business would continue to deteriorate even if they were otherwise following efficient business practices. On the other hand, if the insurer with the older population could rate them as a separate class and establish a new rating class for new business, they could offer competitive prices.

It is fairly obvious that these criteria clash: some point toward community rating, while others point to allowing rate variation based on group differences. It is not surprising, therefore, that deciding on rating regulations is a controversial process.

Although a choice of what rating factors to allow insurers to use in varying rates is important, it is perhaps less important than deciding *how much rate variation should be permitted in total*. Do policy makers want to limit the variation of all rating factors in combination to a range of 2:1, 3:1, 4:1 or some larger ratio? Once that decision is made, the choice of factors to be used in varying rates is somewhat secondary in importance. Whatever they are, policymakers could start with the constraint that the rating factors in combination should not produce a total premium variation that exceeds an agreed-upon ratio. As noted earlier, this is the approach in Maryland, which allows the use of just age of enrollees and firm location, but limits the total variation for these two factors in combination to ±40 percent.

Approaching rating limits in this way will—in addition to narrowing the premium gap between high-risk and low-risk small groups—help to reduce the year-to-year variation that an individual employer may experience. But it will not eliminate the possibility of substantially higher rate increases for some firms—for example, if age rating is permitted and two or three employees in a small firm pass an age threshold in the same year. It might be wise, therefore, to also place a fixed limit on the

amount by which any individual employer's rate can rise above the "trend" or average increase that all employers experience (for example, 10 percent or 15 percent per year).

The evidence about what degree of rate variation produces good results is not definitive. Early qualitative studies of small-group insurance reforms showed that a variety approaches seemed to work well, although virtually everyone agreed that some rate compression was desirable.[6] A study of the Maryland approach, mentioned earlier, found that the relatively tight rating rules in that state also seemed to work well, although that system has other characteristics that make it unique, most notably that all insurers must offer the same standard package of benefits, though add-ons are permitted.[7] It does seem clear that reducing allowable rate variation will not lead to significant reductions in the number of uninsured people. That result is not surprising, however, since the proportion of high-risk groups, which are the groups that realize premiums savings, is relatively small. On the other hand, adjusted community rating does not seem to have caused large numbers of low-risk groups to drop out of the market. The possibility that low-risk groups might leave the group market may be made worse by the fact that in Delaware individuals who are self-employed can choose either to buy coverage as a one-person group or to buy individual coverage. Low-risk people are more likely to choose the individual market if rate compression is imposed in the small-group market. Our informants indicate that this is already happening—that very small, low-risk employers, and not just the "groups of one," are funding coverage for employees through the individual market because it is less expensive to do so. Agents have an incentive to encourage this practice because commission rates are higher in the individual market. The tendency for low-risk "micro firms" to find coverage outside the small-group market will be strengthened if rapid escalation of medical costs causes health premiums to continue to rise as a proportion of total business costs.

If policymakers in Delaware believe that it is important to do something to respond to small employers' concerns about extremes in rate variation, a reasonable way to achieve that objective is to adopt rating rules that reduce the range of variation that insurers can use in setting premiums for small groups of different risk. Our interviews indicate that there is some support for that policy change. A number of our interviewees reacted favorably to the idea, and none argued vehemently against it. In general, people seemed open to the idea of considering a variety of options to deal with this problem. One advantage of the adjusted community rating approach is that the only cost to state government is the cost involved in enforcing new rules. But it may be wise to not compress rates any further for "groups of one," since this segment of the group market is very much like the individual market, in the sense that it is easy for people to buy coverage only when they think they will need it. Compressing rates further for groups of one would make this response even more likely.

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[6] Mark A. Hall, *Health Insurance Market Reform Study,*
http://www.phs.wfubmc.edu/pub_insurance/pub_insurance.cfm

[7] Elliot K. Wicks, *Assessment of the Performance of Small-Group Health Insurance Market Reforms in Maryland*, prepared for the Maryland Health Care Commission, by Health Management Associates, February, 2002.

Risk Adjustment

Another way to achieve rate compression in the small-group market is to eliminate any financial advantage that risk segmentation might produce. If there is no financial advantage to be gained by attracting low-risk people and avoiding high-risk people or for segmenting people into separate rating groups, insurers will not do that.

One way to eliminate the financial advantage for risk segmentation is by adopting a system of risk adjustment among insurers. The concept of risk adjustment is simple enough: insurers that attract enrollees of below-average expected risk transfer funds to insurers that attract enrollees of above-average expected risk to make up for risk-related differences in expected medical claims. The objective is to fully offset any differences in medical expenses incurred by different insurers that are due to the risk profiles of the people they insure. Insurers would still bear risk, of course—the risk that is random and unpredictable, such as when an enrollee has an accident or becomes newly ill. Since the risk is unpredictable, insurers cannot use it as a basis for risk-rating anyone. And insurers would still absorb cost differences that are due to differences in their administrative efficiency and their ability to control the cost of medical services.

If the system worked perfectly, an insurer would gain no advantage by trying to attract low-risk people and avoid high-risk people because they would get the same net premium (after transfers) regardless of the risk of the enrollee. Insurers would compete to attract low-risk and high-risk employer groups equally. There would be no reason to use medical underwriting. Instead, insurers would price their products on the assumption that everybody they enroll would be of average risk. They would have no reason to charge more to higher-risk groups and thus would voluntarily community rate everyone. An individual insurer's premiums for different groups would reflect just benefit levels and degrees of cost sharing.

Of course, in real life no risk-adjustment mechanism being used or being contemplated would achieve perfect risk adjustment. The systems in place today are not very accurate in predicting cost differences for individuals, but they do not have to be. They only have to be good at predicting differences from group to group, and they are sufficiently accurate at doing that.[8] However, even a good risk-adjustment mechanism might not provide adequate transfers to offset the cost of enrolling the very small proportion of individuals who incur extraordinarily high costs—for example, people with AIDS or people with conditions that require constant re-hospitalization and long term regimens of very expensive drugs. Insurers might still have an incentive to avoid enrolling such people. One way to deal with that problem is through "post-claims" risk adjustment. The insurers that end up with enrollees who present certain very expensive conditions would receive special after-the-fact transfers from other insurers to offset their disproportionately high costs. (This

[8] *Proposed Method of Incorporating Health Status Risk Adjusters into Medicare+Choice Payments, Report to Congress,* prepared by the Health Care Financing Administration, Office of Strategic Planning, Research and Evaluation Groups, Division of payment Research, March 1, 1999.

amounts to a form of reinsurance, about which much more will be said later in this paper.)

In general, however, pre-claims ("prospective") risk adjustment is preferable to post-claims ("retrospective") risk adjustment, apart from the exception for very high-cost cases. Pre-claims risk adjustment appropriately provides no extra compensation to an insurer that incurs higher costs because they are less efficient and less effective in controlling provider costs and costs of treatment. The objective is to have a risk-adjustment mechanism in place that still gives strong incentives to insurers to contain costs, regardless of the risk profile of the enrollees in their plan.

A number of different risk-adjustment mechanisms are being used, including by Medicare, some large employers, and purchasing pools.[9] But no state except New York has applied a risk-adjustment scheme to all insurers operating in the individual or small-group markets. The process is complicated, especially when insurers offer different benefit packages. What kind of transfer is appropriate if one insurer offers a much more generous benefit package than another? It would certainly be possible to define a standard benefit package representing the common benefits covered by almost all plans and then make transfers based on just that portion of benefits or the actuarial equivalent. Another possible problem arises because some insurers may cover so few groups that they really do not have a statistically valid "risk profile," so it would be difficult to determine how they should participate in risk-adjustment transfers.

Although implementing a risk-adjustment mechanism in Delaware's small-group market would not be a simple task, the state, because of its small population and relatively small number of insurers of any size might have some real advantages. It would be an interesting test case.

Reinsurance

Traditional Private Reinsurance

Reinsurance is a mechanism for protecting individual insurers against the risk of incurring high costs associated with an expensive episode of care—for example, a very premature baby cared for in a neonatal intensive care unit for months or someone with AIDS. Insurance as a concept is based on the law of large numbers: while it is not possible to predict accurately whether any individual will need expensive medical care, it is possible to predict with considerable accuracy how much medical care will be needed by a large population group in the aggregate. But unless the group is very large, there is still considerable unpredictability about whether someone within the

[9] For a very good discussion of the various approaches, as well as a good discussion of the issues surrounding risk adjustment, see Kanika Kapur, "Risk Adjustment Methods and their Relevance to "Pay-or-Play," *Supplement E to the Report: Challenges and Alternatives for Employer Pay-or-Play Program Design: An Implementation and Alternative Scenario Analysis of California's "Health Insurance Act of 2003" (SB 2),* prepared by the Institute for Health Policy Solutions, for the California Health Care Foundation and the California Managed Risk Medical Insurance Board, March 2005, http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=109629&subTopic=CL499&subsection=reports

group will incur *extremely* high medical expenses in any year. It is for this reason that smaller insurers will often choose to buy reinsurance: they will pay premiums to a reinsurer to pass on the risk of incurring an extremely high-cost case to that reinsurer. In effect, the reinsurer assumes most if not all the liability for any costs per insured individual or per episode of care that pass some high threshold (in effect, the deductible). When they buy reinsurance, insurers do not need to set aside so much in reserves to protect themselves against the possibility of having to pay for an extremely costly case, so then can offer somewhat lower premiums to everybody. And if they incur very large unexpected claims costs, they do not have to raise rates in a subsequent year to make up the loss; so premium increases are likely to be more stable and predictable from year to year.

Reinsurance of this type is widely available, and no new public policy is necessary to ensure its continued availability. But there are other types of reinsurance that could be implemented only with passage of state legislation.

Reinsurance Pools for Selected Individuals or Groups

Some states, including Delaware, have experimented with an arrangement that allows insurers to identify certain small groups or individuals within a group that they wish to reinsure. They have a limited time after initial enrollment to decide who will be reinsured in the pool. In essence, this approach amounts to a high-risk pool for high-risk small groups. This differs from traditional reinsurance because the insurer has to identify the high-risk enrollees or groups *before the fact,* that is, before the costs are incurred. To make this work, insurers have to be reasonably accurate in identifying the individuals or groups that will actually incur the highest costs, and they may not always be successful in doing that. Once the people to be reinsured are selected (though they do not know they have been so identified), the insurer then pays a premium to have the risk transferred, or "ceded," to the risk pool.

If the premiums are not sufficient to cover the actual costs, then insurers in the small-group market that are participating in the reinsurance program are assessed to make up the pool's shortfall. This approach is used in Connecticut with some success.[10] In some other states, enrollment is very low.

Large insurers are often not supportive of such mandatory insurance mechanisms. They argue that they do not need such protection because they are large enough to self-insure even for very large losses. So from their perspective, the effect is to force them to prop up smaller insurers, because if the premium is insufficient to cover the losses and an assessment is necessary, the bulk of the assessment will come from the large insurers. Apparently accepting this argument, some states have exempted the largest insurers, typically Blue Cross and Blue Shield plans.[11] But without their participation, the system is difficult to sustain, and several states abandoned their efforts. If the objective of such reinsurance mechanisms is to create an environment

[10] Deborah Chollet, "The Role of Reinsurance in State Efforts to Expand Coverage," Issue Brief, Vol. V. No. 4, AcademyHealth, Oct. 2004.
[11] Chollet.

where it is easier for smaller insurers to stay in the market, the large insurers' arguments for not participating may not be convincing from a public interest standpoint. Even if the large insurers do not *need* the reinsurance mechanism because they can reinsure themselves, they still have the opportunity to take advantage of it and to pass on some costs to the smaller insurers.

As noted earlier, Chapter 72 of the Delaware Insurance Code lays out the details of a program that would allow small-group insurers to reinsure selected groups or specific individuals in a group. However, insurers can choose whether to participate in this program—that is, whether to be a "reinsuring carrier" or to remain as a "risk-assuming carrier." Apparently, only two small carriers ever elected to be a reinsuring carrier and participate in the program, and neither does so any longer. So for all practical purposes, the law is dormant.

The Delaware law has these provisions: Within the first 60 days of insuring a group, a participating insurer can identify either a group or individuals within a group that they wish to reinsure. Once the participating insurer has incurred costs for a reinsured individual in a year of $5,000, the reinsurance program would pay 90 percent of the cost up to $50,000 and 100 percent thereafter. The insurer's liability, in other words, is limited to $10,000. The premium for a group that is reinsured would be 150 percent of the base rate, which already is adjusted for the risk of the group. And the reinsurance rate for an individual would be 500 percent of the base rate. If the premiums are insufficient to cover the reinsured losses, the program assesses the *participating* carriers according to their share of small-group premium revenue. Since almost no carriers chose to participate—most notably not the large carriers that account for the bulk of the small-group business—there has really been no one to assess if the premiums were not sufficient to cover the losses. There is no real spreading of risk among carriers, which probably explains why the program has never seen any real use.

Subsidized Reinsurance

To this point, we have discussed approaches that involve spreading risk among all the insurers in the small-group market. A different approach depends on *government* to finance the reinsurance, in effect spreading the risk across all taxpayers. In some respects, this approach is very similar to the standard private reinsurance model discussed initially. The principal difference is that the insurers do not have to pay a premium to pass on the risk of the high-cost cases. Instead, government absorbs the costs. The insurer is responsible to pay all the costs up to a threshold—for example, $80,000—and then the government pays a large proportion of the costs thereafter—for example, 90 percent. Sometimes there is a "corridor" of costs for which government is responsible—above some amount government pays, but above another higher amount the insurer resumes responsibility. Typically, the insurer would still be responsible for a portion of the costs even when the reinsurance threshold is reached, so that the insurer would have some incentive to contain costs of the episode of illness.

This government subsidy would allow insurers to offer reduced premiums, since they would not pay for much of the high-cost care their enrollees need. The lower the threshold point where the reinsurance takes effect, the lower the premium that insurers will charge but, of course, the larger the cost to government. For example, the Healthy New York reinsurance system covers 90 percent of costs between $5,000 and $75,000, and that represents more than one-quarter of the insurers' total medical spending.[12] Such subsidized reinsurance would also reduce year-to-year variations because insurers would be less concerned about the fact that some change in the group's characteristics could increase the probability that the group will incur high medical claims.

Reinsurance of this type also protects insurers from some of the worst consequences of adverse selection.[13] Even if they end up with a disproportionate number of high-risk people who then incur high costs, they do not have to bear much of that cost. Being relieved of this risk should make insurers somewhat less reluctant to take on higher-risk groups and that should be reflected in some reduction in the premium, since they do not have to set aside as much to cope with the possibility of realizing adverse selection.

It is not entirely clear what approach insurers would use in lowering premiums in this instance. The reinsurance should make them more willing to take on high-risk enrollees because they are no longer high risk for the insurer. Insurers might reason that they should pass on the cost reduction in the form of lower premiums for just higher-risk applicants. But because higher-risk enrollees are probably more likely to incur costs in general, including costs below the threshold for reinsurance, it is more likely that insurers would reduce premiums more or less across the board, making coverage somewhat more affordable for everyone.

The advantage of this government-financed reinsurance approach is that it spreads risk very broadly, across the whole tax-paying population, and it does not compel insurers, enrollees, employers, or anybody else to do anything. The market is left to work. The disadvantage is that it is an expensive way for government to achieve rate compression. And even if the objective is to increase insurance coverage by lowering premiums, it is not very efficient in the sense of having a given allocation of government monies produce the largest possible expansion in the number of insured people. The dollars would not be spent in a "target efficient" way because much of subsidy would go to people who are already buying coverage with their own money. Premiums can be expected to decline across the board, for everybody purchasing insurance. Most of the people who benefit from the lower premium are people who are already buying insurance and who thus are paying for the high-cost cases with their own money when they pay premiums. Government dollars would thus mostly substitute for private dollars. This result is undesirable if the overriding objective is produce the greatest result with the fewest dollars. It may be desirable if the objec-

[12] Randall R. Bovbjerg, "Implementation of Reinsurance as Part of the Massachusetts Roadmap to Coverage," Report for the Blue Cross Blue Shield of Massachusetts Foundation, the Urban Institute, August 2005.
[13] Bovbjerg, 2005.

tive is to spread risk in the broadest possible way and to move toward a social insurance model like Medicare.

The size of the reinsurance subsidy can be kept lower and the target efficiency improved by limiting the reinsurance program only to insurance offered to groups that often cannot afford the high cost. For example, the reinsurance might be available only for coverage provided to small firms that employ predominantly low-wage workers. These firms often do not buy coverage because of the cost, and thus many employees of such firms lack coverage. Reinsurance subsidies available only to this group would not produce much substitution of public dollars for private dollars already being spent. This strategy may be appropriate for expanding insurance coverage, but it does little to address the problem that is the focus of this paper—the variation in rates across groups in the small-group market and the instability of rates. Reinsurance limited to certain groups would affect the rates for only those groups, not the small-group market as a whole.

The analysis suggests that market-wide reinsurance may not be the most desirable tool for achieving rate compression in the small-group market, even though it might be justified to achieve other objectives.

Another possibility would be to use a variant of an approach mentioned earlier, which depends on insurers prospectively identifying high-risk groups or individuals that they would like to reinsure. But instead of having the insurers pay a premium, which is often supplemented by an assessment on all insurers, the high-cost expenses incurred by those in the reinsurance pool could be financed by government, which spreads the risk more broadly. In effect, this approach amounts to a high-risk pool for the small-group market, except that the individuals or groups who are reinsured are not aware of their special status. This options scores better on the criteria of target efficiency than market-wide reinsurance because only the high-risk groups or individuals in the group are being subsidized.

Purchasing Pools

The idea of having small employers join together to collectively purchasing coverage through some kind of purchasing pool is an idea that has broad appeal. The hope is that by participating in such an arrangement, small employers would be able to realize some of the advantages of bargaining power and administrative economies of scale that large employers enjoy. Purchasing pools are often also perceived as a mechanism for pooling risk—bringing together higher-risk and lower-risk firms and charging them rates that reflect the risk of the average group in the pool. The problem with this idea is that it will not work in a market where other insurers are free to vary rates based on risk. Lower-risk groups will be able to get a better deal outside the pool and will leave. Higher-risk groups will initially get a better deal inside the pool and flock to this less expensive source of coverage. The result will be a spiral of adverse selection and financial failure.

Purchasing pools may have merit for other reasons, but they cannot separately pool risk or reduce the range of risk variation except under two conditions. They can do so if some groups are required to use the pool as their source of coverage if they choose to get coverage. For example, if all groups with 25 or fewer employees that offer coverage were required to go through a purchasing pool, the pool could community rate, and rates would obviously be compressed. Pools can also pool separately if large subsidies are available only to those who use the pool as their source of coverage. Then even low-risk people will not leave the pool because they would have to give up the subsidies.

A Combination Approach

In deciding on ways to deal with the problem of excess rate variation in the small-group market, policy makers can consider options that combine some of the concepts that underlie the approaches described above. One such approach involves using the state employees' plan as a sort of "safety valve" for the small-group market. The approach combines elements of a high-risk pool, subsidized reinsurance, and collective purchasing. It might work as follows.

The state would allow small employers to buy coverage through the state employees' plan. It might be wise to make the benefit package for small employers somewhat less rich to make the coverage closer to what small firms typically buy and to bring down the price. But the pricing would reflect the economies of scale and bargaining power that the state enjoys as a large purchaser. In other words, the pricing would be the same as it would be if state employees were getting that benefit package. There would be no medical underwriting, so all employers would pay the same rate. Any small employer would be free to participate.

Under these circumstances, for some small employers it would be cheaper to buy through the state employees than from the normal market. The state enjoys some administrative economies of scale because of its large size, and it probably realizes some price savings because insurance carriers are eager to have a share of this large group. The state could also probably bring some pressure to bear on its carriers to encourage providers to provide more cost-effective services. Large private employers frequently use such strategies. Coverage costs might be cheaper for these reasons, which might attract a number of small firms of average risk.

But the employers that would find coverage within the state plan most attractive would be higher-risk small employers, since they would not be "rated up" because of their group's characteristics. Of course, this means that the state plan would experience some adverse selection; it would attract a disproportionate number of higher-risk employers. Agents would be likely to channel high-risk groups to the state plan because the cost through the state plan would be less. If the state responded by raising rates, that would defeat the purpose. The state would not raise rates but instead would explicitly subsidize the cost attributed to any adverse selection. This approach bears similarities to state-subsidized reinsurance or a high-risk pool, since govern-

ment is bearing the cost of the high-cost claims. (It is the claims that make the premium subsidy necessary.)

To ensure state employees that they would not end up paying for adverse selection in the form of increased premiums or reduced benefits, it would be important to create a separate risk pool for the small firms so that the state would know just what the subsidy amount needs to be, and that amount would be funded separately from the insurance plan for state employees.

Previously in this paper, we have warned that if a purchasing pool uses more lenient rating rules than those that apply in the "outside" market, the subsequent adverse selection would cause costs and premiums to rise and the pool to disintegrate as it loses all the lower-risk groups. But that would not happen in this instance because the subsidies would keep the rates from rising even though the pool would experience some adverse selection. That would mean that the state employees' plan would continue to attract small firms of *average* risk, which would help to spread the risk and keep the claims costs and the need for subsidies down. In essence, the state plan price would set an upper limit on the price of small-group coverage. On the other hand, the state would attract very few of the lowest-risk groups. The adverse selection problem might also be aggravated by the fact that, in Delaware, self-employed persons are considered to be a "group of one" and subject to the small-group laws. Adverse selection is especially likely for such individuals—and to a lesser extent for other "micro groups"—because people can wait until they anticipate needing expensive medical services to buy coverage. To provide some protection against this problem, the program should probably permit groups of any size to join the state plan only during a one-month open enrollment period, and if they leave the plan, they should not be permitted to rejoin for perhaps three years.

This approach has several advantages. Like subsidized reinsurance it requires government subsidies, but unlike reinsurance, the subsidies are targeted to just the high-risk groups and not spread across the whole small-group market. So the target efficiency is greater: fewer government dollars are needed to achieve a given cost reduction for high-risk groups. The state employees' plan acts as a safety-valve for high-risk employers; most would choose the state plan. The result would be that rates for everyone else would be lower (in total by approximately the amount of the total state subsidy), and the rate variation for small groups of all kinds in the normal market would be less, since most of the high-risk groups would be in a different risk pool.

While some people might have reservations about having the state "compete" with other insurers, this line of reasoning is not very convincing. Private carriers serve as third-party administrators for the state's self-insured plan, and they would be administering this portion of the business as well. So, in the aggregate, the private sector would not be "losing" any business. To deflect any criticism of this sort, agents could be paid their normal commission for enrolling groups in the state plan.

Another advantage of this approach is that it provides small businesses with a source of coverage that is more efficient because of the state plan's greater purchasing clout

and administrative economies, including the fact that the state would not have to do medical underwriting.

A possible disadvantage is that the state is not experienced in serving small employers, and that process would involve some significant administrative costs. But the third-party administrators for the state employees' plan *are* experienced at serving small employers. They would administer the plan for small employers as well, adapting the processes they already have in place with no great increase in fixed costs. No new bureaucracies would be necessary.

Private-Sector Initiatives and Experiments

Over the years, several private-sector efforts have been initiated to make health coverage more affordable and available for small employers. We summarize three of those efforts.

New Castle Chamber of Commerce Plan

Through its Benefits Connection insurance program, the New Castle Chamber of Commerce offers members a variety of health insurance products provided by AmeriHealth and Blue Cross Blue Shield of Delaware, among others. This program, which has been in place for about 25 years, offers HMO, PPO, HSA, and point-of-service options. Approximately 500 employers buy health insurance through the Chamber. Most of them are small, insuring five or fewer lives. Although the plan does not change carriers frequently, the Chamber puts out the plan for bid every year. Coventry, Cigna, and other insurers have offered coverage through the Chamber plan in the past. Information materials provided to potential participants note that over the years, premium increases have been lower than those of the overall market.

The fact that 500 employers participate in the Chamber plan is evidence that it serves a need. But the approach does not prevent participating employers from experiencing wide variation in premiums for comparable coverage. This is not surprising because the Chamber plan is competing with the market as a whole. If the Chamber were to try to compress rates to bring down premiums for the higher-risk employers, rates for lower-risk employers would inevitably rise, and they would be able to find less expensive coverage outside the Chamber plan from insurers who were willing to give them a price reflecting their lower risk. The loss of lower-risk participants would cause the Chamber plan's claims costs to rise even more, leading to a further exodus of all but higher-risk employers. The results would be unsustainable.

State Chamber of Commerce Health Plan

Since January of 2004, the State Chamber of Commerce has offered a health plan through Coventry that is available to members with up to 200 employees. By not using agents or charging any commission, typically about 6 percent, the Chamber hoped to be able to offer coverage that would be less expensive than would be available to their member elsewhere. Individual employers pay risk-rated premiums, so the premium variation is similar to that of the rest of the small-group market. The

bulk of the approximately 100 employers who participate are small, ranging from 1 to 5 employees, and about 75 percent were previously uninsured or people who have been on COBRA. About 70 percent are firms that were not Chamber members until they decided to buy coverage through the Chamber.

First HealthyChoices

Though not yet offering a product, First HealthyChoices represents an effort by the local Chamber of Commerce in the southern part of the state to introduce an innovative product to small businesses. The supporters hope it will both reduce cost and increase premium stability. The product, to be offered by the Community Health Plan, will attempt to produce savings by identifying potentially costly conditions when people enroll and giving them incentives to immediately seek care and follow a treatment plan to address the health problem. The organizers worked with doctors and hospitals, as well as doing an analysis of data on state employees' medical costs, to understand the factors most responsible for driving up costs. They particularly identified diabetes, coronary heart disease, obesity, and smoking as conditions that would greatly benefit from early detection and management. They further concluded that a major problem in controlling costs is patient lack of responsibility in following through once a condition that needs medical management is identified.

The organizers anticipate being able to tackle this problem by conducting full biometric and blood studies when people enroll to determine the health risks enrollees present and then decide what needs to be done to manage their care. The health coverage will have two levels. Everyone will have the more generous coverage initially, but if they do not get the original medical studies done within 60 days or if they fail to follow the treatment regimen prescribed by their doctor, they will be relegated to a less generous coverage plan. The supporters anticipate that these incentives will have the desired effect of ensuring compliance by most enrollees (80 percent to 85 percent) and that the savings will be in the range of 15 percent to 20 percent.

Because the product will be offered initially only in the last quarter of this year, there is no experience to draw on in assessing the success of this approach. But it seems clear that, whatever its merits, it cannot solve the problem of rate variation. The program will rely on medical underwriting to establish rates, and as noted a number of times, no plan that has to compete with other plans can accept people on a more lenient rating basis without become a victim of adverse selection.

Assessment of Private Experiments

The private-sector efforts to offer affordable coverage (at least those already begun) have met a need: they have enrolled substantial numbers of small employers, including many who previously did not offer coverage. For at least some small firms, they clearly offer a combination of price and value that makes them a "good deal." But approaches such as these cannot solve the problem of wide rate variation among firms in the small-group market because they have no choice but to use medical underwriting and to vary rates based on differences in group risk. For reasons explained earlier, if they tried to compress rates to a substantially greater degree than is typical in the rest of the small-group market, they would not remain financially viable.

Summary and Conclusion

It is clear that Delaware law permits a degree of premium variation in the small-group market that creates problems of affordability for higher-risk employers and for firms that experience a change in the characteristics of their workforce that causes them to be "rated up" from one year to the next.

Solutions to those problems exist, and they all require finding a way to spread risk more broadly so that higher-risk groups bear less of the cost and more of the risk is transferred to others. The transfer can be to other small employers buying coverage. One reasonable way to accomplish this would be to revise Chapter 72 of the Insurance Code to further constrain insurers' ability to vary rates based on risk. Another would be to adopt a risk-adjustment mechanism in the small-group market, so that insurers would have little incentive to charge different rates to different groups. To transfer risk more broadly—across the taxpaying public—the state could adopt a reinsurance arrangement, with the state absorbing a substantial portion of the cost of high-cost episodes of illness. An approach that combines several of these elements would be for the state employees' plan to serve as a source of subsidized coverage for higher-risk small employers.

From the perspective of state government, the easiest and cheapest of these options would be to revise the rating restrictions in Chapter 72, adopting a much simpler and more straightforward approach that starts by establishing a tighter overall limit on rate variation when the effects of all rating factors are combined. Implementing a risk-adjustment mechanism for the whole small-group market has great appeal from the standpoint of spreading risk and rewarding insurers for socially useful behavior. It would not add appreciably to state government costs, but it would involve considerable administrative complexity and require time to be implemented. Government subsidized reinsurance spreads risk very broadly over all taxpayers rather than just within the small-group market, but it is an expensive approach to spreading risk, since many costs now paid privately would be transferred to government. The approach of having the state employees' plan offer subsidized coverage has the advantage of providing small employers with an efficient source of coverage, but the state would have to be ready to absorb costs of some adverse selection. The approach has the benefit of lowering costs for the entire small-group market.

Since the solution to the problem of wide premium variation involves spreading risk more broadly, someone besides higher-risk groups will end up paying more than they do now. But risk spreading is the essence of insurance, and it seems appropriate to adopt state policies that provide protection for high-risk groups and individuals, since they are the very people who are most likely to face the burden of having to pay high medical expenses.